DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445112	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	R **05/29/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREVECCA CENTER FOR REHABILITATION AND HEALING LLC	**329 MURFREESBORO RD** **NASHVILLE, TN 37210**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS A Life Safety revisit survey was conducted on 05/29/2019 for the previous deficiencies cited on 04/08/2019. The deficiencies have been corrected, and no new non compliance was found. The facility is in compliance with all regulations surveyed.	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

POC#1 LSC
45th day 5-25-19
70th day 6-19-19

50 pages total
Received by HCF on April 29, 2019

Trevecca Center for Rehab and Healing-44-5112

Annual Survey Plan of Correction

Traci O'Kelley-Administrator

This plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of care is submitted to meet requirements established by state and federal law.

In the plan of correction, our QAPI committee consists of the following members:

Administrator

Director of Nursing

Asst. Directors of Nursing

Staff Development Coordinator

Activity Director

Dietary Manager

Wound Care Coordinator

Rehab Manager

Business Office Manager

MDS Coordinator

Respiratory Manager

Social Services

Maintenance Director

Housekeeping/Laundry Director

Medical Records

Central Supply

K754

Corrective Action(s) will be accomplished for those residents found to be affected:

The 5 soiled linen and trash receptacles at service elevator on 5th floor, 7 soiled linen and trash receptacles on 4th floor, 6 soiled linen and stored in the corridor at room 302 and 5 soiled linen receptacles at in corridor at room 202 were removed by staff. Staff Development Coordinator began education on 4-23-19 regarding the placement of the barrels/receptacles. Maintenance Director ordered larger receptacles from Amazon on 4-24-19 to keep in the soiled linen room that staff could use so that less carts were on the hallway.

Identifying other residents having the potential to be affected and corrective action taken for prevention:

Maintenance Director provided education for staff regarding not having multiple linen barrels on the floor at the same time as it becomes a potential hazard.

Measures/changes put in place to ensure that deficient practice doesn't happen again:

Ordering of new large soiled linen receptacles to place in soiled utility rooms on each floor. New receptacles should arrive by 4-30-19.

How will corrective actions be monitored/QA program put in place?

Maintenance Director/Housekeeping Director will monitor barrels in the halls weekly for the next 3 months and report findings to the QAPI team. Any negative findings will be reported to the administrator. After 3 months of reporting, the QAPI committee will determine the reporting frequently thereafter.

Compliance 4-30-19

K920

Corrective Action(s) will be accomplished for those residents found to be affected:

Extension cords found in rooms 521 and 218 were removed immediately by maintenance staff on 4-8-19.

Identifying other residents having the potential to be affected and corrective action taken for prevention:

On 4-9-19, all other rooms were checked by maintenance department to make sure that no extension cords were in use.

Measures/changes put in place to ensure that deficient practice doesn't happen again:

The Maintenance Director provided education to staff about the use of extension cords.

How will corrective actions be monitored/QA program put in place:

Maintenance Department/Housekeeping Department will audit rooms monthly and report to QAPI committee their findings for the next 3 months. Negative findings will be reported to the administrator and will be corrected. After 3 months of reporting/compliance, the QAPI team will determine the reporting frequency thereafter.

Compliance 4-9-19

K921

Corrective Action(s) will be accomplished for those residents found to be affected:

The facility developed policies and protocols for the testing and maintenance for patient care related electrical equipment according to NFPA 99, 10.5.2.1.1 (2012 edition).

Identifying other residents having the potential to be affected and corrective action taken for prevention:

Maintenance Director provided education to staff on 4-25-19 regarding Patient Care Related Electrical Equipment (PCREE).

Measures/changes put in place to ensure that deficient practice doesn't happen again:

Administrator will review PCREE binder monthly for compliance.

How will corrective actions be monitored/QA program in place:

Maintenance Department will report findings to the monthly QAPI meeting. Negative findings will be reported to the administrator and corrections will be made as needed. After 3 months of reporting, the QAPI team will determine the reporting frequency thereafter.

Compliance 5-13-19

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K 000	INITIAL COMMENTS Stories: 5 Construction Type: II protected No Plans available Constructed: 1976 Sprinklered: Yes Bed count: 240 A life safety code survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulations Office of Health Care Facilities, on 04/08/2019. During this life safety survey, Trevecca Center For Rehabilitation and Healing was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life Safety from fire, and the related National Fire Protection Association (NFPA) standard 101 (2012 Edition) · All damaged, painted, or corroded sprinklers shall be replaced in accordance with NFPA 25, Standards for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011 Edition)	K 000		
K 232 SS=F	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5	K 232		4-23-19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 4-25-19

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K 232	Continued From page 1 This REQUIREMENT is not met as evidenced by: This deficiency affected 12 of 14 smoke compartments, with the potential to affect all patients, staff and visitors. Based on observations, the facility failed to maintain Aisle, Corridor or Ramp Width. The finding included: 1. Observation on 04/08/2019 at 9:38 AM, revealed 3 clean linen carts stored in the corridor at room 527. NFPA 101, 19.2.3.4 (2012 Edition) 2. Observation on 04/08/2019 at 10:49 AM, revealed 1 clean linen cart and 2 soiled linen carts stored in the corridor at room 209. NFPA 101, 19.2.3.4 (2012 Edition) 3. Observation on 04/08/2019 at 12:59 PM, revealed that during activation of the building's fire alarm, staff relocated wheeled equipment from the corridor into occupied patient rooms obstructing convenient removal of patients on all 4 patient room floors. NFPA 101, 19.2.3.4 (2012 Edition) NFPA 101, 19.2.3.5 (2012 Edition) The Maintenance Director was present when these deficiencies were identified and the Administrator acknowledged these deficiencies during the exit conference on 04/08/2019.	K 232		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour	K 321		4-12-19

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K 321	Continued From page 2 fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations, the facility facility failed to protect the hazardous areas. The findings included: 1. Observation on 04/08/2019 at 11:21 AM, revealed a gap exceeding 1/8 of an inch between the 2 leaves of the dutch door to the dry goods storage room in the kitchen. NFPA 101, 19.3.2.1.2 (2012 Edition) NFPA 101, 8.4.3.4 (2012 Edition) NFPA 101, 6.3.1.7.1 (2012 Edition)	K 321		

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K 321	Continued From page 3 2. Observation on 04/08/2019 at 11:22 AM, revealed the dutch door to the dry goods storage room did not self-close within the frame. NFPA 101, 19.3.2.1.3 (2012 Edition) The Maintenance Director was present when these deficiencies were identified and the Administrator acknowledged these deficiencies during the exit conference on 04/08/2019.	K 321		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to maintain the sprinkler system. This deficiency affected 1 of 15 smoke	K 353		4-22-19

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K 353	Continued From page 4 compartments and had the potential to affected housekeeping staff. The finding included: Observation on 04/08/2019 at 10:20 AM, revealed a painted sprinkler in the clean linen closet by room 417. NFPA 101, 19.3.5.1 (2012 Edition), NFPA 101, 9.7.5 (2012 Edition), NFPA 25, 5.2.1.1.1 (2011 Edition) NFPA 25, 5.2.1.1.2 (2011 Edition) The maintenance director was present when this deficiency was identified, and was later acknowledged by the administrator during the exit conference on 04/08/2019.	K 353		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no	K 363		4-9-19

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K 363	Continued From page 5 impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to maintain the corridor doors. This deficiency affected 2 of 14 smoke compartments, with the potential to affect 4 patients, staff and visitors. The finding included: Observations on 04/08/2019 between 11:50 AM - 11:55 AM, revealed the following patient room doors were not positively latching in the frame: A. 419 B. 515 NFPA 101, 19.3.6.3.1 (2012 Edition) The maintenance director was present when these deficiencies were identified, and were later acknowledged by the administrator during the exit	K 363		

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K 363	Continued From page 6 conference on 04/08/2019.	K 363		
K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to ensure staff was familiar with fire procedures. This deficiency has the potential to affect 15 of 15 smoke compartments and all patients, staff, and visitors. The finding included: Observations and interview on 04/08/2019 at 11:45 AM, revealed staff member #1 on the 5th floor was unfamiliar with the facilities fire procedures. NFPA 101, 19.7.2 (2012 Edition) The maintenance director was present when this deficiency was identified, and was later acknowledged by the administrator during the exit conference on 04/08/2019.	K 712		4-25-19
K 754	Soiled Linen and Trash Containers	K 754		

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K 754 SS=F	Continued From page 7 CFR(s): NFPA 101 Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 This REQUIREMENT is not met as evidenced by: This deficiency affected 12 of 14 smoke compartments, with the potential to affect all patients, staff and visitors. Based on observations, the facility failed to comply with Soiled Linen and Trash Containers regulations. The findings included: 1. Observation on 04/08/2019 at 10:00 AM, revealed 5 soiled linen and trash receptacles (32 gallons each) stored at the end of the corridor at the service elevator on the 5th floor. NFPA 101, 19.7.5.7.1 (2012 Edition) 2. Observation on 04/08/2019 at 10:02 AM,	K 754		4-30-19

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K 754	Continued From page 8 revealed 7 soiled linen and trash receptacles (32 gallons each) stored at the end of the corridor at the service elevator on the 4th floor. NFPA 101, 19.7.5.7.1 (2012 Edition) 3. Observation on 04/08/2019 at 10:46 AM, revealed 6 soiled linen receptacles (32 gallon each) stored in the corridor at room 302. NFPA 101, 19.7.5.7.1 (2012 Edition) 4. Observation on 04/08/2019 at 10:47 AM, revealed 5 soiled linen receptacles (32 gallon each) stored in the corridor at room 202. NFPA 101, 19.7.5.7.1 (2012 Edition) The Maintenance Director was present when these deficiencies were identified and the Administrator acknowledged these deficiencies during the exit conference on 04/08/2019.	K 754		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general	K 920		4-9-19

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K 920	Continued From page 9 precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to maintain the electrical equipment. This deficiency affected 2 of 15 smoke compartments, with the potential to affect 4 residents, staff and visitors. The findings included: Observations on 04/08/2019 between 9:46 AM - 11:00 AM, revealed extension cords in the following locations: A. Room 521 B. Room 218 The maintenance director was present when these deficiencies were identified, and were later acknowledged by the administrator during the exit conference on 04/08/2019.	K 920		
K 921 SS=D	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3.	K 921		5-13-19

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K 921	Continued From page 10 Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility to comply with electrical equipment testing and maintenance requirements. The findings included: Document review and interview with the Maintenance Director on 04/08/2019 at 11:57 AM, revealed the facility failed to provide policies and protocols for the testing and maintenance of patient-care related electrical equipment. NFPA 99, 10.5.2.1.1 (2012 Edition)	K 921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445112	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	04/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 921	Continued From page 11 The Maintenance Director was present when these deficiencies were identified and the Administrator acknowledged these deficiencies during the exit conference on 04/08/2019.	K 921		